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From Statistics to Diagnostics:

Medical Certificates, Melancholia, and “Suicidal Propensities” in Victorian Psychiatry

“The question of the patient being suicidal should never in any case of melancholia be left unconsidered, and the risk of his becoming suicidal should never in any case be left unprovided for.”¹

T.S. Clouston, Clinical Lectures on Mental Diseases (1887)

Introduction

Historians have drawn attention to some of the ways in which the budding science of statistics came to bear upon suicide in nineteenth-century Europe, a development in which social environment became central to the perceived incidence of self-accomplished deaths within a nation or group of people, and which culminated in Durkheim’s famous 1897 study.² In contrast, medical certificates of insanity enabled a different kind of statistical knowledge about suicide to arise within the walls of the Victorian asylum. The category “suicidal”, transferred from reception orders into admissions registers and onto the pages of patient case books, produced tables displaying the number of patients with “suicidal propensities” residing in the asylum at any one time. Whether a patient was deemed “suicidal” or not was in the first instance pronounced prior to admission, as it was one of the items of information required by the reception order accompanying the medical certificates of insanity.

Olive Anderson makes the following remark about suicidality in her now classic study on suicide in Victorian and Edwardian England:

“What circumstances would have suggested a risk of suicide to a Victorian or Edwardian family doctor who had read a standard manual or attended a course of lectures on mental disease? First and foremost, he assuredly would’ve known that every patient suffering from mental depression (and hence incipient melancholia) was a potential suicide, but that suicide was comparatively rare in other forms of insanity.”³

That patients diagnosed with melancholia were prone to exhibit “suicidal propensities” had become something of a medical fact in the last few decades of the nineteenth century – the period from which Anderson finds her sources to support this remark. Yet only a generation earlier medical texts on melancholia contained remarkably few references to “suicide”, and fewer still to the adjective “suicidal”. This article is chiefly concerned with the second concept, constituting as it did a novelty in medical language in the nineteenth century.⁴

“Suicide” had gradually begun to replace “self-murder” prior to the nineteenth century (though not in a straightforward and uncomplicated way⁵). But the adjective it spawned – “suicidal” – did not correspond to the former in any simple way; as a medical concept it has its own particular history. To some extent, both the emergence and later the growing prevalence of the term may be explained as resulting from the view, held by a vast number of published British psychiatrists in the late nineteenth century, that suicide was not an abominable, unspeakable act, but rather explicable, even at times understandable.⁶ This approach made the potential “signs” that a person might be contemplating self-destruction a legitimate, indeed a valuable, object of study. But the term did not make its medical debut in psychiatric literature. Its use in medical psychology grew in the first instance out of the

reception orders accompanying the medical certificates of insanity that were gradually introduced in the first decades of the century. These documents required the person having a “lunatic” committed to the asylum to give a “yes” or “no” answer to the question of whether the patient was considered “suicidal” or not.

Over a decade ago David Wright lamented the lack of “scholarly research on the process of certification”.⁷ As he rightly argued, medical certificates are important documents for the historian of psychiatry as they constituted “the raw data upon which medical superintendents drew their early aetiological and pathological theories of insanity”.⁸ Wright went on to suggest that there is scant evidence of textbook theory in these certificates, usually filled out and signed by general practitioners with perhaps little or no training in the diagnostics of mental disease.⁹ However, while it may be debated whether medical certificates of insanity expressed much in the way of contemporary medical opinion on mental disease, the data which emerged from these documents were important in shaping such opinion. Moreover, the statistics produced within the asylum were central to legal concerns and a concomitant sense of need for greater standardization of rules and practices governing asylums and licensed houses. In this article, I hope to draw attention to some of the consequences of compulsory medical certification and related statistical practices for medical theories of mental disease.

A number of scholars have noted the multiple meanings attached to “suicide” in (particularly the second half of) the nineteenth century.¹⁰ It has been suggested that “attempts” were not necessarily seen as “failed” acts of suicide, but could be cast by physicians as intended “to procure sympathy or to produce remorse”.¹¹ “Suicidal” is best understood as a distinct concept alongside “suicide” and the equivocal “attempt”, though it

overlapped with both, particularly the latter.¹² Shepherd and Wright have drawn attention to the question of medical certificates and statistics of “suicidal” patients in the asylum. The authors note the multivalent meaning of the term, suggesting that “suicidality included a range of behaviours and intentions, from the description of individuals who had clearly attempted self-murder to depressed patients who expressed an often imprecise ‘wish to die’.”¹³ They go on to discuss the perceived prevalence of “suicidal tendencies” in melancholia, quoting asylum physician Thomas Brushfield as representative of the view “that every case of melancholia had the potential for suicidal action.”¹⁴ Physicians based such assumptions, the authors argue, on their clinical experience,¹⁵ which was supported by *statistics* showing “a marked correlation between suicidality and the two states associated with depressed mood – mania with depression and melancholia.”¹⁶ The emergence of the term “suicidal” as a medical phenomenon did indeed become important both for diagnostic descriptions of melancholia as well as for the attention given to this form of insanity in psychiatric literature. There was, however, nothing inevitable about these developments. They were effected through asylum recording practices and the wealth of statistics these produced. I suggest that there is something to be gained from subjecting this productive relationship between medical theory, practice, and statistics to closer historical scrutiny.

A patient’s suicidality had possible legal implications.¹⁷ Asylum superintendents were responsible for the wellbeing of their patients; a death by suicide within the walls of the asylum (or, for that matter, soon after a patient had been discharged) was at best an ugly stain on that asylum’s reputation and at worst a legal disaster. Thus, late-nineteenth-century alienists devoted much time and energy to the diagnostics and treatment of the most “suicidal” of all forms of insanity: melancholia. A shift occurred within dominant medical

opinion in Britain from a belief that suicide was a possible outcome of melancholia in the early nineteenth century to one which held that a majority of melancholics were “suicidal” at the dawn of the twentieth. This was no insignificant change; nor was it an inevitable one. As Allan Young has demonstrated, a psychiatric syndrome does not “possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources.”¹⁸ It follows that the instability and malleability of disease concepts¹⁹ and the symptoms that accompany them can be interrogated through a closer look at the relationship between melancholia and the term “suicidal” in British medicine in the nineteenth century. Thus, in this article I hope to sketch out some of the events, acts, and processes which produced “suicidal” as a medical phenomenon and a defining symptom of melancholia in late-Victorian psychiatry. In doing so, I will suggest that “suicidal” never shared a simple, *causal* bond with “suicide”.

The Emergence of “Suicidal”

Wynn’s Act of 1808 had allowed for county asylums to be established as institutions providing for pauper lunatics.²⁰ In the subsequent years, admission to licensed private houses came to require legal documentation certifying the mental state of the person taken into care, a provision which was eventually extended to pauper asylums.²¹ Thus, when the Care and Treatment of Lunatics Act and the Regulation of Asylums Act (hereafter “the Lunacy Acts”) were passed in 1845²² medical certificates were already in use to ensure that an individual taken into an asylum or licensed private house was not wrongly committed but was indeed “a lunatic [or an insane person, or an idiot, or a person of unsound mind] and a

proper person to be confined”.²³ To an extent, then, the Acts constituted “a consolidation of ‘lunacy reform’” begun at the end of the previous century.²⁴ Such earlier developments can also be seen as the first bricks in the bureaucracy which was rapidly constructed in the aftermath of the Acts. Every county in England and Wales was compelled to erect its own pauper asylum within three years. The Acts moreover created a permanent national body, the Lunacy Commission, to oversee the implementation of the Acts across England and Wales. For our present study, two consequences of the birth of this authority are of particular concern: First, the yearly reports which asylums were required to submit to the Commission produced a wealth of statistical information about the people residing in these institutions. Second, almost immediately after the initial stipulations of the Acts had come into force, these were built upon through a relentless flow of circular letters from the Commission to the asylums requesting various kinds of information, from “a copy of your present Diet Table”²⁵ to whether post-mortem examinations were performed on a regular basis.²⁶

The Lunacy Acts had provided a clear template for the medical certificate and reception order, listing the various “particulars” required, such as “age”, “sex”, “place of abode”, whether this was the patient’s “first attack”, and whether he or she was “epileptic”, “suicidal”, or “dangerous to others”.²⁷ The meaning of the label “suicidal” given to people upon admission to the asylum was ambiguous and multivalent, as physicians themselves recognized. In the case of private patients, the statement was often filled out by a spouse, relative, or friend, while reception orders belonging to pauper patients might be filled out and signed by a workhouse official or a magistrate. A wide-ranging number of actions (including refusal of food, or talking about death) could result in a “yes” to the question of

whether the patient was “suicidal” or not. Following from this, Shepherd and Wright hold that there may have been a number of different motives behind an affirmative answer, suggesting for instance that in the case of pauper lunatics “Poor Law officials might have, in some cases, exaggerated the danger of suicide in order to secure access to a dwindling resource of beds”,²⁸ and that “[o]nce incarcerated, many suicidal patients did not demonstrate such tendencies”.²⁹ This suggests that the category “suicidal” was often deployed in ways that were at odds with its “true” meaning. However, while the concept was undeniably a broad one, as we shall see below it *acquired* its meaning through the context – specifically the documents – that created it and through the various purposes it served.

One of the ways in which the concept “suicidal” was made meaningful was in the practice and theory of diagnostics. The Lunacy Acts stipulated that all asylums and licensed houses were required to keep an admissions book and that once a new patient had been received into the institution his or her details must be entered into it within two days, with a diagnosis following within the next week.³⁰ Thus, a diagnosis was usually reached in light of the presence or absence of “suicidal propensities.” Moreover, a letter from the Lunacy Commission circulated shortly after the passing of the Acts set out the format and content of entries into the more comprehensive asylum case book. On the first page of each new case physicians were asked to state the presence of “morbid” or “dangerous” “propensities” in conjunction with the diagnosis.³¹ Such information became part and parcel of the statistics presented to the Lunacy Commission in the annual reports asylum superintendents were required to compile. Statistics on ‘suicidal’ patients could, then, easily be cross-referenced with the statistics on the various forms of mental disease represented across an asylum population. This practice of comparative statistics enabled physicians to argue that patients

diagnosed with melancholia were more likely to exhibit “suicidal propensities” than those suffering from other forms of insanity.

In sum, instructions circulated by the Commission were in the first instance aimed at creating uniform practices across England and Wales in order to better facilitate the inspection and evaluation of asylums by the Commissioners. However, while legal concerns regarding proper care and treatment were at the heart of these developments, the standardization of asylum practices crucially shaped diagnostic criteria, which in turn were reinforced through the statistics which the standardization practices had produced. We will now take a closer look at how suicidality and melancholia were mutually constituted within this context.

Nosological Shifts

What might a diagnosis look like, and whence did asylum physicians derive the categories they deployed? As historians have noted³², there was a dearth of home-grown British medical literature on insanity in the first half of the nineteenth century. No standard British nosology existed. The system of classification presented in James Cowles Prichard’s *A Treatise on Insanity* (1835)³³ was inspired by its author’s training under French asylum physician J.E.D. Esquirol.³⁴ Esquirol had attempted to replace melancholia with his idiosyncratic *lypemanie* (“sadness mania”), a sub-category of the ubiquitous *monomanie*.³⁵ While the former did not catch on, Prichard wholeheartedly adopted “monomania”, and in doing so tried to do away with melancholia as a specific disease category. Monomania was for a time a popular term of classification in British medicine and as such it obscured the boundaries of melancholia as a distinct nosological category.³⁶

Prichard did not have much to say about suicide, and even less about “suicidal” patients. His contemporary George Man Burrows showed some interest in “the suicidal propensity” and “suicidal delirium”³⁷, however, it was Forbes Winslow’s *The Anatomy of Suicide* (1840) that signaled a growing theoretical interest in suicidality within British medical psychology. The statistical tables presented in this work related only to “suicide” – medical certificates were already in use, but prior to the birth of the Lunacy Commission there was no regular nationwide reporting on the number of “suicidal” patients in British asylums. However, Winslow devoted considerable space to the problem of caring for patients with “suicidal propensities”. Most such lunatics suffered from “suicidal mania”, he argued, the suicidality prompted by “an undue excitement of the mind.”³⁸ Ample use of the term “suicidal” was also made by John Charles Bucknill and Daniel Hack Tuke in the first edition of their *Manual of Psychological Medicine* (1858), one of the most widely read textbooks of the century. They did not, however, deploy the concept specifically in relation to melancholia (which they, following Esquirol, subsumed under monomania). Rather, like Winslow, they were chiefly concerned with “suicidal mania”. The authors suggested that while it may be true that many insane suicides resulted from a “profound melancholy”, it was equally the case that a large number of melancholics showed a powerful aversion to death. Moreover, suicide in the mentally diseased could also result from delusion, excitement, or “shock”. For these reasons, they argued, it would be warranted to speak of suicidal mania as a separate form of madness, one which incorporated all these possibilities.³⁹

A decade later Henry Maudsley discussed suicidal lunatics both from the point of view of the “suicidal impulse”, which he saw as a morbid reflex mirroring the “homicidal impulse”, and in relation to acute melancholia and mania, forms of mental disease which he grouped

under the umbrella category “affective insanity”. Maudsley paid more attention to the category of “suicidal” patients than Bucknill and Tuke had done. Specifically, he emphasized that “those who are suicidal should be carefully watched at all times”⁴⁰, a view that was rapidly becoming central to discussions on melancholia and suicidality. Significantly, Maudsley included “refusal of food” in the category of suicidal propensities;⁴¹ illustrating another way in which physicians were increasingly ascertaining the suicidality of melancholic patients.⁴² Moreover, Maudsley’s nosology formed part of a shift away from traditional conceptualizations of melancholia which had emphasized *sadness* as the primary symptom, toward a focus on *mental pain*. This subtle but significant change in symptomatology was at least in part a product of the physiological model of emotional pathology favored by Maudsley and inspired by the “psycho-physiology” of people such as W.B. Carpenter and Thomas Laycock in Britain and Wilhelm Griesinger in Germany. Within this explanatory framework where sensory-motor reflex action served as a metaphor for a psychological equivalent, it was easy to conceive of pathological emotionality as a form of “mental pain” analogous to physical pain.⁴³ This idea of mental pain would, as we shall see below, become important to a conception of melancholia which held “suicidal propensities” to be part of the internal logic of the disease.

Thomas Brushfield, medical superintendent at Parkside asylum in Cheshire until 1869 and thereafter at Brookwood in Surrey, paid particular attention to the question of suicidal patients on the wards. At Parkside, he had detailed tables assembled which combined the statistics on suicidal patients with those on diagnostic categories. His tables indicated that half or more of the persons diagnosed with melancholia were considered to exhibit “suicidal propensities”. This category was further broken up into those who had “attempted” and

those who had “meditated” suicide, groups which were almost equal in number.⁴⁴ In his annual report to the Commission for the year 1854, Brushfield remarked upon the difficulty in caring for “suicidal” patients, suggesting that “[t]his class at all times causes great anxiety to the medical officers, as notwithstanding the greatest vigilance on the part of the attendants, fatal cases will sometimes occur; no instance of the kind has, however, happened during the past year.”⁴⁵ According to the figures emerging from the Lunacy Commission’s yearly reports, Brushfield’s figures reflected the norm. Physicians would increasingly call upon asylum statistics to illustrate what was rapidly becoming a medical “fact”.⁴⁶ Thus, in 1890 Samuel Strahan was able to invoke the Lunacy Commission’s figures in his pre-Durkheimian “sociological” study *Suicide and Insanity* in support of the same conclusion as that which Brushfield’s statistics had indicated some decades previously: that of all suicidal lunatics the majority were melancholics, and of all melancholics, the majority were suicidal.⁴⁷

At the same time as asylum physicians – and the Lunacy Commissioners – became increasingly concerned with the problem of “suicidal” patients, theoretical interest in melancholia intensified. When the third edition of Maudsley’s *The Pathology of Mind* was published in 1879, he had revised his earlier nosology which had seen melancholia grouped together with mania and moral insanity, instead classifying the former as a distinct disease category with its own chapter. His take on suicidal melancholics echoed the prevailing view among Victorian psychiatrists at this time: “Suicidal feelings and attempts are common in melancholia”, he suggested, “so much so that one suspects their actual or possible existence even when they have not been openly manifested.”⁴⁸ “Suicidal” had, it appeared, become a defining symptom of melancholia – to the point where the presence of suicidal propensities must be suspected even when these were not observable to the physician. In order to explain

this inherent suicidality, psychiatrists called upon the biological “facts” of the disease, particularly the “mental pain” referred to above.⁴⁹ This psychological symptom with a strong physiological basis, all-consuming and without adequate cause, made suicidal propensities a “natural” progression in the course of the disease.⁵⁰ Cast as a morbid disturbance in brain function, mental pain compromised the evolutionary “love of life”⁵¹, making suicidal feelings compatible with “the general course of human nature”.⁵² In this way, suicidality could be explained as part of the intrinsic logic of melancholia, so that even when suicidal propensities could not be observed, *their presence was inferred from the diagnosis itself*. During the 1880s and early 1890s, prominent British physicians Thomas Clouston, George Savage, G.F. Blandford, and Charles Mercier all published textbooks on mental disease in which it was forcefully argued that melancholics were by far the most suicidal of all lunatics and that even when this suicidality did not openly manifest itself one should nonetheless take precautions in the event the propensity was merely latent.⁵³

There was a strong desire among alienists, as well as within the Lunacy Commission, to assure the public and each other that the asylum was a safe – indeed the safest – place for people with “suicidal propensities”. Consequently, considerable resources were devoted to surveillance and treatment, and physicians emphasized the importance of taking care to properly ascertain a patient’s suicidal tendencies.⁵⁴ The Commissioners, for their part, expanded upon existing recording and standardization practices, ensuring that medical officers deployed the same diagnostic categories and were consistently recording the number of suicidal patients residing in their hospital. Illustrative of these developments is a letter circulated among asylum superintendents in the spring of 1877 asking for a report (in addition to such figures supplied yearly) on “the number of Patients in your Institution on the

22nd instant who at present are considered to have suicidal propensities.” This brief and to the point letter was accompanied by an equally brief table to be filled out and returned, indicating the total number of patients in each institution and how many of these were considered to be “suicidally disposed.”⁵⁵

The Meaning of “Suicidal”

There was no denying that the suicidal propensity was particularly strong and notoriously common in melancholic patients – the figures emerging from the annual Lunacy Commission reports suggested as much. But of what did this suicidality consist? What meanings were conjured up by the term “suicidal”? How were melancholic patients assigned to this category? The patient books at Brookwood, where Brushfield was appointed medical superintendent in 1869, offer an apt illustration. As Shepherd and Wright have suggested, the data coming out of the Surrey County Asylum largely reflected the prevailing medical view about suicide and melancholia. In the case of some patients one or several “attempts” were recorded, while in others the attending physician deduced the suicidal propensity from other indicators. Thus, fifty-year-old Ann Field was described as “very much depressed and expressed an intense feeling of melancholy, *as if* she would do herself an injury – she could give no reason for this. Simply expressing the feeling.” Similarly, Hannah Pink, who was also labeled suicidal, was reported as being “[a]pathetic and indifferent to all around her. She speaks rarely and answers reluctantly.” No other allusions to her purported suicidality were made. In the case of Henry Challin Kitchin, another suicidal melancholic, no reason was given for his suicidal tendencies other than that he “has a marked despondent expression, the result of melancholia, has undefined fears of the future”. Overall, Brookwood’s “suicidal” melancholics ranged from those who had reportedly tried to throw themselves out of

windows or cut their throat, to those who would not eat, to those who were reported to be “despondent”, those who claimed to have committed a great sin and must be punished, and those who expressed a fear of being killed.⁵⁶ Thus, “suicidal” was a broad and multivalent concept, as is aptly summed up in the following excerpt from an article on “one hundred cases of melancholia” in the *British Medical Journal*:

“Thirteen men and 8 women attempted suicide – these were all of the simple acute cases. Of the same class 23 men and 15 women meditated suicide, or threatened it, while 2 women of the confusional class and 4 men and 1 woman of the hypochondriacal class threatened or spoke of suicide. It will thus be seen that 66 per cent of the cases were suicidal”.⁵⁷

While such statistical analyses repeatedly affirmed the claim that melancholics were overwhelmingly suicidal, they also prompted questions about what, exactly, this broad label was intended to convey. In the 1870 annual report for Brookwood asylum Brushfield had suggested that medical certificates could produce ambivalent data.⁵⁸ Bucknill had previously drawn attention to this problem, arguing that the “facts indicating insanity” which physicians were required to state were often not sufficiently specific.⁵⁹ There was, however, guidance available for those who needed it. Anyone who was unsure of how to correctly fill out a medical certificate could consult John Millar’s *Hints on Insanity* (1861) which offered a detailed step-by-step description of how each part of the certificate should be dealt with.⁶⁰ In a revised and expanded edition published in 1877 Millar had added helpful notes on how to determine whether the patient’s mental state was “excited”, “melancholy”, or “usually calm but occasionally excited”. According to Millar, the chief signs indicating melancholy were “great nervous excitement”, “delusions” of guilt with expectations of impending punishment, being “depressed in spirits” and “melancholic and desponding”, and “making attempts at

self-destruction”.⁶¹ These “hints” largely mirrored the section on melancholia in Millar’s nosology, where suicidality was highlighted as a defining characteristic.⁶² “Indeed”, the author suggested, “every case of melancholia should be looked upon as having a suicidal tendency.”⁶³

Brushfield quoted this very phrase when he returned to the problem of medical certification in an article published in *The Lancet* in 1880. Here he expressed support for Bucknill’s insistence on specificity and attention to detail before going on to highlight a different conundrum. The format of medical certificates tended to obscure any distinction between two groups of patients who were “a danger to themselves”: the patient with “no suicidal motive” who nonetheless “imperils his own life by various acts”, and those *with* “suicidal tendencies”.⁶⁴ Brushfield illustrated the first category with the case of a woman who was admitted to the asylum after having “cut her left hand off because she thought it was Scripturally wrong”. He suggested that while this patient was described as ‘suicidal’ on her certificate, the label was incorrect since

“[t]he only reason for believing her to be suicidal was that of the act of dismembering, but her motive for doing this was a non-suicidal one, and it is in part alluded to in the facts communicated by her husband and sister. [.....] She had recently lost a child, and after grieving over it she became the subject of auditory hallucinations. [.....] She asserted, as her reason for cutting her hand, that she had been told to do so by the voices”.⁶⁵

George Savage raised similar concerns regarding the statistics over the total number of “suicidal” patients at Bethlem Hospital, suggesting that while “we have from 20 to 30 per

cent of our patients described as suicidal”, this figure was misleading “for though many speak of suicide, but few really determine to attempt it.”⁶⁶ Thus, he concluded that “I do not think that more than five per cent of our admissions are ‘actively suicidal’”.⁶⁷

Brushfield had no such reservations about people diagnosed with melancholia, however. On the characteristics of the second class of patients at risk of self-damage he was clear, declaring that “I would urge upon all medical practitioners the necessity of regarding all cases of melancholia as having suicidal tendencies”.⁶⁸ Following from this, he stressed that any “facts” indicating suicidal propensities derived from direct observation of a patient, or which had been communicated by family and friends “should be detailed in the [medical] certificate.”⁶⁹ Brushfield drew on a recent case of acute melancholia to indicate in what such facts might consist. This patient’s suicidal tendencies were apparent, he argued, in that he expressed “[m]elancholy views about religion; thinks he has committed sins”, that he had “repeatedly threatened to drown himself”, and “that he has twice attempted to make suicidal attempts, and that he has very restless nights.”⁷⁰ There was, then, no skepticism about the validity of the “suicidal” label when it was attached to melancholic patients. Echoing Maudsley’s statement above, Brushfield was adamant that the suicidal propensity was always a potential presence in melancholics “whether or not there have been threats or attempts indicating it; – the depressing nature of the symptoms, if it does not manifest itself at first, always tends to develop it.”⁷¹

Conclusion: Statistics, History, and the Production of Knowledge

Despite Brushfield’s certainty, the problems he had drawn attention to regarding the “suicidal” label produced by medical certificates had led some of his contemporaries to begin to question the assumption that physicians must always be vigilant against suicidal

propensities in melancholia. Were melancholics really as “suicidal” as asylum statistics seemed to indicate? Thomas Clouston suggested that this might not be the case. Taking the last 729 cases of melancholia which had come under his care he arrived at the following conclusion:

“Among those 729 there were 283, or about two-fifths (39 per cent), who had actually attempted to commit suicide. In many cases, no doubt, the attempts could scarcely be regarded as being very serious. In addition to this number there were 301 cases, or two-fifths more, that had spoken of suicide, or given some indication that it had been in their minds. That makes 584 out of 729 melancholics, or four out of five of the whole, that were more or less suicidal. No wonder, therefore, that the loss and perversion of the instinct of the love of life is regarded as one of the chief symptoms of melancholia. I am quite sure, however, from what I know of the disease, that the actual risk of suicide being seriously attempted or accomplished is much less than those figures seem to show.”⁷²

Savage expressed a similar view regarding young female patients diagnosed with melancholia who were admitted “into the asylum with the very worst characters as far as suicidal tendencies are concerned”. The risk of death being effect was, however, minimal. In most such cases, he remarked, “there is much more cry than wolf, in my experience”.⁷³

Olive Anderson notes this conundrum in her study of Victorian and Edwardian suicide. She remarks that while “each year thousands of patients were admitted with ‘suicidal’ against their names, only a dozen or so successful suicide attempts were annually made within asylum walls.”⁷⁴ Concurring with Savage that asylum statistics on “suicidal” patients may have been misleading, she suggests that it was perhaps more likely that “only a quarter or less of those stated on admission to have suicidal tendencies were in reality actively or

dangerously suicidal.”⁷⁵ As previously noted, Shepherd and Wright arrive at a similar conclusion where asylum statistics are concerned. They suggest that “the term ‘suicidal’....must be viewed with a degree of contextual sensitivity,” since the ways in which it was deployed meant that it ‘included a wide range of behaviours and clinical features.’”⁷⁶ This leads the authors to conclude, like Anderson, that the practices which produced statistics on “suicidal” lunatics were likely to have obscured the boundary between patients who were “actively suicidal” and those who had been wrongly assigned the “suicidal” label.⁷⁷

This perspective importantly attends to the problem of statistical practices, suggesting that these do not produce “incontestable figures”⁷⁸ but are complex historical events which must be interrogated. However, the argument that the “real” number of “suicidal” patients was masked by the way this category was applied on medical certificates and in asylum reports attempts to detach the concept “suicidal” from the contexts that produced and conferred meaning upon it. This approach, then, holds the statistics to be faulty, while at the same time suggesting that there exists – or, rather, could have existed – a “real” number of suicidal patients which these statistical practices, due to their *defectiveness*, failed to recover. In other words, it appears to assume that there was – or should have been – a “true” meaning of “suicidal” that existed outside of or prior to the intellectual practices that produced it. It is not suggested in what this “true” meaning consists. It is implied, however, that the clue is in a presumed affinity of “suicidal” to “suicide”, that correct usage of the former depends upon its likeness to the latter. However, as I have tried to show in this article, there was no simple, corresponding relationship between “suicidal” and “suicide”.

The recording and counting practices which created the medical concept “suicidal propensities” and wedded it to melancholia did not generate “false” information, they

produced kinds of knowledge which had, just like other kinds of scientific knowledge, an internal logic. In other words, “conventions defining objects really do give rise to realities.”⁷⁹

The creation of “suicidal” as a category on medical certificates generated numerical data on the suicidality of asylum patients. Following the creation of the Lunacy Commission, asylum physicians were required to assign a diagnostic category to each patient and record this diagnosis in conjunction with the presence or absence of “suicidal propensities”. Such information had to be assembled into statistical tables and supplied to the Commissioners on a yearly basis, and enabled physicians to argue that melancholics were by far the most “suicidal” of all lunatics. This argument soon became self-perpetuating and circular – patients diagnosed with melancholia were suspected of harboring suicidal propensities even if these were not evident to the physician. The various standardization practices described above facilitated a shift in nosological theory, which in turn reinforced the knowledge produced by asylum statistics. Thus, the statistics on “suicidal” patients were not “inaccurate” or “misleading”; they were productive of medical knowledge about people. Ian Hacking aptly sums up what is at work (and at stake) here when he suggests that “enumeration requires categorization, and that defining new classes of people for the purposes of statistics has consequences for the ways in which we conceive of others and think of our own possibilities and potentialities.”⁸⁰

In sum, then, I have tried in this article to draw attention to the kind of knowledge that was produced through the recording and counting of the “suicidal propensities” of people admitted to Victorian asylums. The concept was created and shaped by these practices and, through them, by its perceived closeness to melancholia, a relationship that

was central to how both melancholia and “suicidal” came to be understood by British physicians in the second half of the nineteenth century.

ENDNOTES

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¹ Thomas S. Clouston, *Clinical Lectures on Mental Diseases*, 2nd edn (London: J & A Churchill, 1887), 107.

² Ian Hacking, *The Taming of Chance* (Cambridge, Cambridge University Press, 1990). See also Maria Teresa Brancaccio, “‘The Fatal Tendencies of Civilized Society’: Enrico Morselli’s *Suicide* and Quantitative Studies in Nineteenth-Century Italy” and David Lederer, “Sociology’s ‘One Law’: Moral Statistics, Modernity, Religion and German Nationalism in the Suicide Studies of Adolf Wagner and Alexander von Oettingen”, in *The Politics of Suicide: A History of Suicidology before Durkheim*, ed. Maria Teresa Brancaccio, Eric Engstrom and David Lederer. See also Émile Durkheim, *Suicide: A Study in Sociology* (London: Routledge and Kegan Paul, 1952 [1897]).

³ Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon Press, 1987), 383.

⁴ To my knowledge, the earliest uses of the adjective “suicidal” occurred in the eighteenth century, and were metaphorical, such as in reference to political policy. The *Oxford English Dictionary* lists no reference to the word “suicidal” prior to the nineteenth century. George Man Burrows mentioned “the suicidal propensity” in 1828; G.M. Burrows, *Commentaries on the Causes, Forms, Symptoms, and Treatment, Moral and Medical, of Insanity* (London: T&G Underwood, 1828), 417. Forbes Winslow referred to “suicidal propensities” in the *Anatomy of Suicide* published in 1840. He was, however, concerned with what he called “suicidal mania” rather than melancholia; Forbes Winslow, *The Anatomy of Suicide* (London: H. Renshaw, 1840). “Suicidal” turned up occasionally in the first five years of the *Journal of Mental Science* (initially the *Asylum Journal of Mental Science*); from 1859 onwards the term appeared there with increasing regularity. John Conolly discussed suicidality in relation to melancholia in the 1840s; John Conolly, “Clinical Lectures on the Principle Forms of Insanity: Lecture IX: Melancholia – The Treatment Concluded,” *The Lancet*, 1, 1170 (January 1846): 110-116. One of the earliest mentions of the term ‘suicidal melancholia’ in published material appeared in 1853: William P. Kirkman, “On an Instance of Suicidal Melancholia,” *The Lancet*, 62, 1562 (August 1853): 117.

⁵ MacDonald and Murphy suggest that this lexical change was inseparable from a broader, conceptual shift from “self-murder” as an unpardonable sin to “suicide” as an unnatural and unfortunate act calling for compassion rather than condemnation. Michael MacDonald and Terence R. Murphy, *Sleepless Souls: Suicide in Early Modern England* (Oxford: Clarendon Press, 1990), 144-175. For a discussion of the word itself, see p. 145.

⁶ For instance, Charles Mercier, consulting physician on mental disease at Charing Cross Hospital, remarked that “there is no such misery as that of melancholia; and under the pressure of this feeling suicide may be the natural and quasi-normal course to take.” Charles Mercier, *Sanity and Insanity* (London: Walter Scott, 1890), 350.

⁷ David Wright, “The Certification of Insanity in Nineteenth-Century England and Wales,” *History of Psychiatry*, 9 (1998): 268.

⁸ *Ibid*, 269.

⁹ *Ibid*, 288.

¹⁰ Anderson, *Suicide*; Anne Shepherd and David Wright, “Madness, Suicide, and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint,” *Medical History*, 46 (2002): 175-196; Howard I. Kushner, “Suicide, Gender, and the Fear of Modernity,” in *Histories of Suicide: International Perspectives on Self-Destruction in the Modern World*, ed. John Weaver and David Wright (Toronto and London: Toronto University Press, 2009); Sarah Chaney, “Suicide, Mental Illness and the Asylum: The Case of Bethlem Royal Hospital, 1845-1875,” (MA diss., University College London, 2009).

¹¹ Olive Anderson, “Prevention of Suicide and Parasuicide: What Can We Learn From History?,” *Journal of the Royal Society of Medicine*, 82 (November 1989): 642. “Parasuicide” is, perhaps, a curious choice of word to describe a phenomenon in the Victorian period. It was briefly in favor in the 1970s and 80s and was, according to the man who invented the term, intended to denote “a non-fatal act in which an individual deliberately causes self-injury or ingests a substance in excess of any prescribed or generally recognized therapeutic dosage”, and where death was not necessarily the aim. Norman Kreitman et al., *Parasuicide* (London: John Wiley & Sons, 1977), 3. I am grateful to Chris Millard at the Centre for the History of the Emotions, QMUL, for alerting me to Kreitman’s work. As Shepherd and Wright (note 10) suggest, however, nineteenth-century ideas about attempted suicide remains “relatively uncharted territory” (179).

¹² Explicitly aiming to expand upon Shepherd and Wright’s study, Sarah Haley York investigates the perception, care, and treatment of “suicidal” patients in the Victorian asylum. While she notes the dilemma of statistics on suicidality, opting instead for a “qualitative” study of case notes, York makes no conceptual distinction between “suicide” and “suicidal”. S.H. York, “Suicide, Lunacy and the Asylum in Nineteenth-Century England” (PhD diss., University of Birmingham, 2009).

¹³ Shepherd and Wright, “Madness”, 179.

¹⁴ *Ibid*, 188.

¹⁵ *Ibid*, 189.

¹⁶ *Ibid*.

¹⁷ The perceived relationship between suicide and insanity also had important legal implications outside the walls of the asylum, particularly in the case of completed suicides. Laragy discusses some of the ways in which medical discourse on suicide challenged the need for the temporary insanity verdict in cases of self-accomplished death. See Georgina Laragy, “‘A Peculiar Species of Felony’: Suicide, Medicine, and the Law in Victorian Britain and Ireland” in *The Politics of Suicide*, ed. Brancacciob et. al.

¹⁸ Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton, NJ: Princeton University Press, 1997), 5.

¹⁹ Adrian Wilson, “On the History of Disease Concepts: The Case of Pleurisy,” *History of Science*, 38 (2000): 271-319.

²⁰ Elaine Murphy, "The Administration of Insanity in England 1800 to 1870," in *The Confinement of the Insane: International Perspectives, 1800-1965*, ed. Roy Porter and David Wright, (Cambridge: Cambridge University Press, 2003), 337.

²¹ Wright, "Certification", 272-274.

²² *An Act (8 & 9 Victoria c. 100) for the Regulation of the Care and Treatment of Lunatics* (1845); *An Act (8 & 9 Victoria c. 126) to Amend the Laws for the Provision and Regulation of Lunatic Asylums for Counties and Boroughs, and for the Maintenance and Care of Pauper Lunatics in England* (1845). Similar legislation was passed for Scotland in the following decade: *An Act (20 & 21 Victoria c. 71) for the Regulation of the Care and Treatment of Lunatics, and for the provision, Maintenance, and Regulation of Lunatic Asylums in Scotland* (1857).

²³ Care and Treatment of Lunatics Act, Schedule (D.), Section 48.

²⁴ Wright, "Certification", 274.

²⁵ Lunacy Commission, Circular Letters, Letter no. 69, May 7, 1857, The National Archives, Kew, Ref: MH51/236.

²⁶ Lunacy Commission, Circular Letters, Letter no. 127, February 5, 1870, The National Archives, Kew, Ref: MH51/237.

²⁷ These templates underwent minor modifications with the subsequent amendments of the Lunacy Act in 1853 and 1862.

²⁸ Shepherd and Wright, "Madness", 194.

²⁹ *Ibid*, 195.

³⁰ Care and Treatment of Lunatics Act, Sections 50 & 51, 82.

³¹ Lunacy Commission, Circular Letters, Letter no. 8, January 9, 1846, The National Archives, Kew, Ref: MH51/236.

³² See e.g. W.F. Bynum, "Theory and Practice in British Psychiatry from J.C. Prichard (1786-1848) to Henry Maudsley (1835-1918)," in *History of Psychiatry: Mental Illness and Its Treatments, Proceedings from the 4th International Symposium on the Comparative History of Medicine – East and West*, ed. Teizo Ogawa (Osaka: Saikon, 1982), 204.

³³ James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (London: Sherwood, Gilbert and Piper, 1835).

³⁴ So impressed was Prichard with Esquirol's work that *A Treatise on Insanity* was dedicated to the latter. *Ibid*, vii.

³⁵ J.D.E. Esquirol, *Mental Maladies: A Treatise on Insanity* (Philadelphia: Lea & Blanchard, 1845 [1838]), 202. For Esquirol's approach to suicide and insanity, see German E. Berrios and M.A. Mohanna, "Suicidal Behaviour: Clinical Section," in *A History of Clinical Psychiatry: The Origins and History of Psychiatric Disorders*, ed. German E. Berrios, and Roy Porter (London and New Brunswick, NJ: The Athlone Press, 1995).

³⁶ John Charles Bucknill and Daniel Hack Tuke, *A Manual of Psychological Medicine*, (London: J & A Churchill, 1858); Henry Maudsley, *The Physiology and Pathology of the Mind* (London: Macmillan, 1867); Harrington Tuke, "On Monomania and Its Relation to the Civil and Criminal Law," *Journal of Mental Science*, 13 (1867): 306-314. John Conolly also argued against melancholia as a distinct disease category, but suggested instead that it was 'a

variety of maniacal affection'. John Conolly, "Clinical Lectures on the Principal forms of Insanity: Lecture VII," *The Lancet*, 1, 1166 (January 3, 1846): 1.

³⁷ Burrows, *Commentaries*, 417-418. Burrows referred to suicidality as "feature of melancholia" in his section on "suicide", but made no reference to "the suicidal propensity", or to "suicide", in his section on melancholia.

³⁸ Winslow, *Anatomy of Suicide*, 49. For more on Winslow and suicide see Ian Marsh, "The Uses of History in the Unmaking of Modern Suicide" in *The Politics of Suicide*, ed. Brancacciob et. al.

³⁹ Bucknill and Tuke, *Manual of Psychological Medicine*, 202-206.

⁴⁰ Maudsley, *Physiology and Pathology of the Mind*, 441. See also e.g. W.H.O. Sankey, *Lectures on Mental Diseases* (London: John Churchill, 1866), 45; Thomas N. Brushfield, *Report of the Medical Superintendent of the Surrey Lunatic Asylum for the Year 1870* (Reigate: Batten and Davies, 1871), 19.

⁴¹ Maudsley, *Physiology and Pathology of the Mind*, 254.

⁴² See also e.g. James Adam, "A Case of Melancholia Presenting some Exceptional Features, Prolonged Refusal of Food, and Forced Alimentation," *British Medical Journal*, 1, 1416 (February 1888): 349; Sankey, *Lectures on Mental Diseases*, 46-47; Clouston, *Clinical Lectures*, 112.

⁴³ For a brief discussion of how Griesinger theorized pathological emotions within a physiological framework, see Åsa Jansson, "Mood Disorders and the Brain: Depression, Melancholia, and the Historiography of Psychiatry," *Medical History*, 55 (2011): 396-399. For nineteenth-century psycho-physiology more generally, see Kurt Danziger, "Mid-Nineteenth-Century British Psycho-Physiology: A Neglected Chapter in the History of Psychology," in *The Problematic Science: Psychology in Nineteenth-Century Thought*, ed. William R. Woodward and Mitchell G. Ash (New York: Praeger, 1982); Roger Smith, *Inhibition: History and Meaning in the Sciences of Mind and Brain* (London: Free Association Books, 1992); L.S. Jacyna, "Somatic Theories of Mind and the Interests of Medicine in Britain, 1850-1879," *Medical History*, 26 (1982): 233-258. See also: Maudsley, *Physiology and Pathology of the Mind*; Wilhelm Griesinger, "Ueber psychische Reflexactionen: Mit einem Blick auf das Wesen der psychischen Krankheiten," reprinted in *Gesammelte Abhandlungen, Ersters Band: Psychiatrische Abhandlungen* (Amsterdam: E.J. Bonset, 1968 [1843]); Thomas Laycock, "On the Reflex Function of the Brain," *British and Foreign Medical Review*, 19 (1845): 298-311; William B. Carpenter, *Principles of Human Physiology* (London: John Churchill, 1842).

⁴⁴ *Annual Reports of the Committee of Visitors, Superintendent and Chaplain of the Cheshire Lunatic Asylum for the Years 1854-1869* (Chester: 1854-1869).

⁴⁵ Thomas N. Brushfield, *Report of the Committee of Visitors and Medical Superintendent of the Cheshire Lunatic Asylum for the Year 1854* (Chester: Evans & Gresty, 1855), 8.

⁴⁶ E.g. W.F. Farquharson, "On Melancholia: An Analysis of 730 Consecutive Cases," *Journal of Mental Science*, 40, 169 (1894): 19.

⁴⁷ Samuel A. K. Strahan, *Suicide and Insanity: A Physiological and Sociological Study* (London: Sonnenschein, 1893), 104.

⁴⁸ Maudsley, *The Pathology of Mind*, 3rd edn (London: Macmillan, 1879), 384.

⁴⁹ See e.g. Clouston, *Clinical Lectures*, 35, William Bevan Lewis, *A Textbook of Mental Diseases: With Special Reference to the Pathological Aspects of Insanity* (London: Charles Griffin & Co, 1889), 138.

⁵⁰ E.g. Maudsley, *The Pathology of Mind: A Study of Its Distempers, Deformities, and Disorders* (London: Macmillan, 1895), 177; Mercier, *Sanity and Insanity*, 349-351.

⁵¹ Maudsley, *The Pathology of Mind*, 3rd edn, 178.

⁵² Mercier, *Sanity and Insanity*, 350.

⁵³ Clouston, *Clinical Lectures*; Mercier, *Sanity and Insanity*; George Savage, *Insanity and Allied Neuroses*, (London: Cassell & Co, 1884); G. Fielding Blandford, *Insanity and Its Treatment: Lectures on the Treatment, Medical and Legal, of Insane Patients* (London: Simpkin & Marshall, 1884). See also e.g. W.F. Farquharson, "Melancholia, with Special Reference to Its Characteristics in Cumberland and West-Morland," *The Lancet*, 146, 3760 (1895): 722-726.

⁵⁴ Clouston, *Clinical Lectures*, 114; Mercier, *Sanity and Insanity*, 351. The relationship between suicidality and the argument for surveillance has been considered elsewhere: Shepherd and Wright, "Madness"; Chaney, "Suicide, Mental Illness and the Asylum"; York, "Suicide, Lunacy and the Asylum"; Ian Marsh, *Suicide: Foucault, History, and Truth* (Cambridge: Cambridge University Press, 2010).

⁵⁵ Lunacy Commission, Circular Letters, March 21, 1877 The National Archives, Kew, Ref: MH51/237.

⁵⁶ Brookwood Lunatic Asylum, *Male and Female Casebooks 1868-1872*, Surrey History Centre, Woking, Ref: [3043/5/9/2/3](#); [3043/5/9/1/2](#) [emphasis added]

⁵⁷ Edward N. Bush, "An Analysis of One Hundred Cases of Acute Melancholia," *BMJ*, 2 (1897): 778.

⁵⁸ Brushfield, *Report of the Surrey Lunatic Asylum for the Year 1870*, 20-22.

⁵⁹ J.C. Bucknill, "On Medical Certificates of Insanity," *Journal of Mental Science*, 7 (1860): 82-84.

⁶⁰ John Millar, *Hints on Insanity* (London: H. Renshaw, 1861), 73-84.

⁶¹ John Millar, *Hints on Insanity and Signing Certificates*, 2nd edn (London: H. Renshaw, 1877), 103-106.

⁶² *Ibid*, 24-30.

⁶³ *Ibid*, 25.

⁶⁴ Thomas N. Brushfield, "On Medical Certificates of Insanity," *The Lancet*, 115, 2958 (1880): 712.

⁶⁵ *Ibid*.

⁶⁶ George Savage, "Constant Watching of Suicidal Cases," *Journal of Mental Science*, 30 (April 1884): 17.

⁶⁷ *Ibid*, 17.

⁶⁸ Brushfield, "On Medical Certificates of Insanity," 712.

⁶⁹ *Ibid*.

⁷⁰ *Ibid*.

⁷¹ *Ibid*.

⁷² Clouston, *Clinical Lectures*, 118.

⁷³ Savage, *Insanity and Allied Neuroses*, 169-170.

⁷⁴ Anderson, *Suicide*, 405.

⁷⁵ *Ibid*, 406.

⁷⁶ Shepherd and Wright, "Madness", 194.

⁷⁷ *Ibid*, 194-195.

⁷⁸ Alain Desrosières, *The Politics of Large Numbers: A History of Statistical Reasoning* (Cambridge, Massachusetts: Harvard University Press, 1998), 12.

⁷⁹ *Ibid*, 337.

⁸⁰ Hacking, *The Taming of Chance*, 6. See also, by the same author: "The Looping Effects of Human Kinds," in *Causal Cognition: A Multidisciplinary Debate*, ed. Dan Sperber, David Premack, and Ann James Premack (Oxford: Clarendon Press, 1995) and "Making up People," reprinted in *Beyond the Body Proper: Reading the Anthropology of Material Life*, ed. Margaret Lock and Judith Farquhar (Durham: Duke University Press, 2007).